MO Title V Maternal Child Health Block Grant
FFY 2022 Application/Report Executive Summary

Program Overview

The Title V Program in Missouri is managed by the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH). Martha J. Smith, MSN, RN, is the Title V Maternal Child Health (MCH) Director and Lisa Crandall, BSW, is the Title V Children with Special Health Care Needs (CSHCN) Director. The Title V MCH Services Block Grant application is submitted by DHSS as the designated state agency for the allocation and administration of these block grant funds. DHSS Title V staff and programming are positioned throughout multiple divisions, sections, and bureaus. DCPH serves as the umbrella agency that facilitates access to numerous MCH-targeted programs and provides a majority of the services to the MCH populations. The capacity of Missouri's Title V program is large, encompassing DHSS staff, local public health agencies (LPHAs), and numerous private and community partners. It is through these programs, initiatives, and partnerships that a statewide system is supported to meet the needs of the MCH population. In 2019, estimates for Missouri's MCH population, including women of childbearing age, infants, children, and adolescents, was 2,704,263, comprising 44.1% of the state's total population. This included 1,177,035 women of childbearing age (15-44), 1,527,291 infants, children, and adolescents (<1 to 17), 301,956 of which were children and youth with special health care needs (CYSHCN) in the 2018-2019 period.

Based on the Five Year Needs Assessment completed in the spring of 2020, the Missouri Title V Program identified the following FY2021-2025 state priorities and developed strategies / action plans to address these needs:

1. Improve pre-conception, prenatal and postpartum health care services for women of child bearing age.
2. Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
3. Reduce obesity among children and adolescents.
4. Reduce intentional and unintentional injuries among children and adolescents.
5. Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
6. Enhance access to oral health care services for children.
7. Promote Protective Factors for youth and families.
8. Address Social Determinants of Health inequities.

Five National Performance Measures (NPMs) and three State Performance Measures (SPMs) were chosen to align with the priority needs and are discussed below by population domain. Overall, Missouri retained six performance measures from the previous cycle and added two new measures. Progress will be monitored by tracking

these performance measures. The needs assessment also identified two overarching principles to be applied across all priorities, performance measures, and strategies. These are to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities.

Title V resources are assigned and program activities are implemented to specifically address the identified priorities. Both budgeted dollars and expenditures are categorized and tracked by population served and across the three service levels in the MCH Pyramid: direct health care services, enabling services, and public health services and systems. Both State and Federal MCH funding help sustain the following programming:

- Community Health Services (injury prevention, adolescent and school health)
- Environmental Health (childhood lead poisoning prevention)
- Epidemiology (vital statistics, analytics, surveillance systems)
- Healthy Children and Families (home visiting, newborn health, TEL-LINK, cribs)
- Genetics (newborn screening)
- Early Childhood (developmental monitoring, child care health consultation, inclusion specialists)
- Oral Health (preventive services, community outreach)
- Special Health Care Needs (family partnership, care coordination, assistive technology)
- Women's Health (MCH services, infant & maternal mortality, health services for incarcerated women)
- Nutrition (breastfeeding, obesity prevention)

<u>Women/Maternal Health</u>
Priority: Improve pre-conception, prenatal and postpartum health care services for women of child bearing age.
NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

The health and wellbeing of the mother before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are also more likely to experience better health postnatally and across the life span. According to data from the 2019 Behavioral Risk Factor Surveillance System (BRFSS), 72.5% of Missouri women between 18-44 years of age reported having a preventive health care visit within the past year. This was lower than the 2019 national prevalence of 72.8%. In Missouri, a higher percentage of insured women (79.5%) compared to uninsured women (42.0%) received a preventive visit in 2019. The Missouri Title V program currently funds efforts to improve access to preventive health care for women, including: TEL-LINK which provides referrals to care for women of childbearing age and their families; the Newborn Health Program which partners with community providers to educate the MCH population on health resources

(incl. preventive care); and the Home Visiting Program which facilitates enrollment in MO HealthNet and/or ACA marketplace insurance programs for participants.

Perinatal/Infant Health

Priority: Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

NPM: A) Percent of infants placed to sleep on their backs.

B) Percent of infants placed to sleep on a separate approved sleep surface.

C) Percent of infants placed to sleep without soft objects or loose bedding.

Deaths due to suffocation, congenital anomalies, and Sudden Infant Death Syndrome (SIDS) are the most significant single causes of postneonatal death. Missouri's rate of injury-related death, which includes SIDS, SUID, and suffocation, is nearly three times higher than the national rate (31 per 1,000 live births US vs 70 per 1,000 live births MO). Mothers with less education, lower household income, who are African-American, or who live in rural counties, are significantly less likely to follow safe sleep recommendations. Safe sleep continues to be a priority for Missouri's Title V Program, which is a primary resource for the Safe Cribs for Missouri program, providing safe sleep education and free cribs to eligible families. Title V Home Visiting Program participants also receive intensive education on safe sleep for their infants. Title V provides supplementary funds to support operations of the PRAMS survey, which monitors safe sleep practices in the state, and supports printing and distribution of the *Pregnancy and Beyond* book, which includes information on safe sleep and infant care.

Child Health

Priority: Reduce obesity among children and adolescents.

NPM: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.

Priority: Enhance access to oral health care services for children.

SPM: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

In Missouri, 17% of WIC-enrolled two-to-four year olds were overweight, and an additional 14% were obese. Among older children, 16.3% of Missouri youths aged 10-17 were overweight or obese in 2018-2019, and overweight and obesity were more frequent among 10-13 year olds than among high-school-aged youth. Physical activity levels decline as children get older; while 32% of 6-11 year-old children were physically active every day, only 25% of 12-17 year-olds were.

High levels of physical activity in early childhood are predictors of continued physical activities as children age into young adulthood, underscoring the importance of establishing healthy physical habits in youth. The School Health Program supports school nurses to engage with students and families in addressing overweight/obesity in children. The MCH Services Program contracts with 23 LPHAs to promote physical activity and prevent and reduce obesity among children and adolescents, and the

Building Communities for Better Health LPHA contracts implement policy and environmental changes that increase opportunities for children to engage in physical activity (PA) across multiple settings.

According to National Survey of Children's Health (NSCH) 2018-2019 data, 79.6% of children ages 1-17 years old nationally had a preventive dental visit in the last year. This was a greater percentage than in Missouri (74.6%). A lower percentage of Missouri children age 1-5 years old (48.8%) had a preventive dental visit than their national counterparts (61.0%). This age group also had a lower percentage than Missouri children age 6-11 years old (88.3%) and 12-17 years old (85.9%). 18.7% of Missouri children age 6-11 years had some degree of tooth decay. Missouri Title V supports the Office of Dental Health, which promotes cavity prevention and oral health to school children through literature and programs including providing fluoride varnish at schools statewide.

Adolescent Health

Priority: Reduce intentional and unintentional injuries among children and adolescents.
NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Priority: Promote Protective Factors for youth and families.
SPM: Suicide & self-harm rate among youth ages 10 through 19.

Intentional and unintentional injury continue to be the leading cause of preventable death and hospitalization among Missouri's children. Missouri continues to report higher rates of injury related death and hospitalization than the national average. Between 2013 and 2017, unintentional injury was the leading cause of death among children aged 1 to 15, largely driven by motor vehicle accidents and, increasingly, by upticks in suicide deaths among older youths. Suicide among Missouri adolescents between the ages of 10-24 is the second leading cause of death for this age group (15.2 per 100,000). In 2019, 172 Missourians aged 10-24 died of suicide, making up approximately 15% of all suicides that year. Improving resiliency and mental health among children and youth of all ages will impact suicide and risk-taking behavior. Safe Kids Coalition in Missouri work to provide unintentional injury prevention services to children aged 0-19 years, including addressing teen driver safety. The Adolescent Health Program (AHP) focuses on Social-Emotional Learning, and the Injury Prevention Program, in partnership with AHP, will pilot a Mental Health Crisis Toolkit for families with youth experiencing a mental health crisis. In addition, DHSS will continue participation in the second cohort of the Children's Safety Network Child Safety Learning Collaborative (CSLC) to reduce fatal and serious injuries among infants, children, and adolescents. Missouri's efforts will focus specifically on Suicide and Self-Harm Prevention.

Children and Youth with Special Health Care Needs (CYSHCN)

Priority: Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.

NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

In 2018-2019, 46% of Missouri CYSHCN received care through a system that met medical home criteria, a rate consistent with that of non-CYSHCN. However in 2018-2019, among CYSHCN, those with more complex health needs were less likely to have a medical home (46.9%) than those with less complex health needs (49.7%). Rates of medical home adequacy decline as children age, from 48% among children younger than age 6, to 45% among adolescents 12-17. A survey of 2019 Family Partnership Retreat participant families indicated that families in rural and non-rural counties had approximately equal likelihoods of having a medical home for their child (58% in rural counties; 59% in urban and suburban counties), but families living in rural counties were 15% more likely to receive explicit assistance from their medical home in coordinating care for their child's special health care needs. Data from the 2018-2019 NSCH showed, among children without special health care needs nationally, 49.7% received care through a medical home, compared with 49.0% in Missouri.. This rate is below the HP2030 target of 53.6%. The Bureau of SHCN provides targeted education to enrolling families on the importance of a medical home. Additionally, Title V programs promote health insurance coverage to improve the likelihood that all children will have a medical home and services to address their needs.

Cross-Cutting/Systems Building

Priority: Address Social Determinants of Health inequities.
SPM: Percent of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Qualitative and quantitative data indicate that Missouri continues to experience areas of concern, particularly surrounding outcome disparities in maternal and child health. These include racial disparities, economic disparities, and geographic disparities. Title V Program team members will identify workforce development training on MCH fundamentals, health equity, and racial and social justice to provide foundational skills in the field of maternal and child health. Activities during this grant year will include reviewing training resources, such as the MCH Navigator trainings and MCH Leadership Competencies, establishing training requirements for internal Title V MCH Block Grant-funded programs/staff and external contractors, and implementing a pilot phase with the Title V Core team.

How Federal Title V Funds Support State MCH Efforts

Federal Title V funds provide backbone funding for approximately 150 key staff positions of Missouri's Title V Program. This includes staff who serve children and youth with special health care needs (CYSHCN), such as the Family Partners; epidemiological staff who analyze data to identify priority health needs of the maternal/child population; and staff who focus on women's, newborn, and/or children's health. Staff also provide technical assistance to community partners, such as Safe Kids coalitions and 115 Local Public Health Agencies (LPHAs). Contract funding to LPHAs comprises almost one-third of federal funds to help build community-based systems and expand the resources those systems can use to respond to priority maternal child health issues. The bulk of remaining contract funds are dispersed for home visiting, service coordination, early childhood, and dental health contracts. The majority of state match supports newborn screening testing by the State Public Health Lab, newborn screening follow-up, and direct care for CYSHCN. State funds also support women's health services for incarcerated women and the Sexual Assault Forensic Examination – Child Abuse Resource and Education program. Federal Title V funds allow Missouri to coordinate public health services provided to the maternal child population by working across multiple state programs, engaging community partners and families, and collaborating with public health stakeholders throughout the state to address both ongoing and emerging issues.

MCH Success Story

As a result of participation in the Maternal Child Environmental Health (MCEH) Collaborative Improvement & Innovation Network (CoIIN), Missouri's Title V Program and Childhood Lead Poisoning Prevention Program (CLPPP) developed a strong partnership that enhanced coordination of the system of care to address the needs of maternal, infant, and child populations at risk for, or that experience, exposure to lead. This partnership facilitated more effective lead poisoning surveillance and prevention efforts and ongoing identification and targeting of areas of high risk for outreach and education.

A family with two children moved from the state of California and purchased a home built in the 1880s in a small rural town in Northwest Missouri. In the spring of 2021, during scheduled medical appointments for the children in a nearby state, initial and follow-up tests indicated elevated blood lead levels for both children, with the youngest child having a venous blood lead level of 22. A DHSS lead risk assessor and the local public health agency (LPHA) were notified of the elevated blood levels, and multiple outreach attempts were made. Communication was eventually established with the children's mother, who was very hesitant to allow a risk assessment and home visit. Further exploration showed the mother feared having her children taken away due to the physician saying the family would be "turned in" to CLPPP, and the parents thought they had done something wrong and were "in trouble". Once the misunderstanding was identified, the risk assessor was able to explain the CLPPP risk assessment process, gain the trust of the family, leverage donated supplies and materials from a local source to aid the family with needed cleaning and painting supplies, and provide Renovate Right and other lead prevention booklets to the family. The LPHA nurse assisted the family in finding a local pediatrician for ongoing medical care. The risk assessor was able to identify lead hazards for the family and develop a plan to move forward, and the family was educated on the hazards of lead and was able to address the hazards. The youngest child's venous blood lead level gradually dropped from 22 to 14 over six months. In identifying, addressing and resolving a misunderstanding, local health department service providers linked the family to recommended services, assisted with effective lead remediation, and provided training to the local pediatrician who would provide the follow-up care and blood lead testing.

The success experienced with this family, was in large part due to Title V MCH Block Grant partnership, support and funding. Title V MCH Block Grant funding allowed the program to print copies of the CDC's book for providers, *Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention*. A copy of the book was provided to the previously mentioned pediatrician, who was also enrolled in one of the CLPPP's provider trainings. With patience, perseverance and clear and consistent communication, the risk assessor and local public health nurse were able to overcome a barrier to service based on a pre-existing misunderstanding, develop a plan to address the family's and children's needs, work with the family to secure medical care, and ensure the medical provider received appropriate training.